DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 9/3/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC # 1	445242	A. BUILDING _____ B. WING _____	C 07/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide dignity for one (#6) of six residents reviewed. The findings included: Resident #6 was admitted to the facility on January 25, 2012, and re-admitted on May 27, 2012, with diagnoses including Multiple Cerebral Vascular Accidents (CVA), Respiratory Failure, Pneumonia, Tracheotomy, Colostomy, Urosepsis, and Dysphagia (difficulty swallowing). Observation in the resident's room and near the resident's door in the hallway, on June 25, 2012, at 10:30 a.m., revealed a strong fecal odor. Observation on June 26, 2012, at 10:25 a.m., in the resident's room with Certified Nurse Assistant (CNA) #1 and Licensed Practical Nurse (LPN) #1 revealed a strong fecal odor. Interview with CNA #1 and LPN #1 while in the resident's room confirmed the odor and revealed the odor was from "burping" the resident's colostomy bag. Observation on June 26, 2012, at 3:30 p.m., in the resident's room with the resident's visitor confirmed the odor and that it came from the	F 241 F 241	Please consider this plan of correction Greystone's Health Care Center's credible allegation of compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission of that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects the desire to continually enhance the quality care and services provided to the residents and are submitted solely as a requirement of the provisions of Federal and state law. Corrective Action and Identify areas having the potential to be affected: Resident #6's colostomy bag was changed on 6/26/2012. Products will be used for resident #6 to reduce the odor when air is released from the colostomy bag. Identifying Other Residents Two additional residents colostomy products were reviewed by the unit managers and determined the odors were contained.	8/9/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelley Turner — TITLE: Administrator — (X6) DATE: 8/3/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 resident's colostomy and it was "embarrassing." Observation and interview, on June 27, 2012, at 7:25 a.m., outside of the resident's room in the hallway and then in the resident's room with LPN #2 revealed a strong odor of feces. Interview with LPN #2 while in the resident's room confirmed the odor was from "burping" the resident's colostomy and was not respecting the resident's dignity.	F 241	Systemic Changes: Unit managers will review residents with colostomies twice a week for 2 weeks then weekly for 4 weeks then monthly for 2 months to determine if products are appropriate and odors contained. The staff development coordinator will complete education with the licensed nurses and certified nursing assistance to report uncontrolled odors from colostomy products. Monitoring: Results of the audits will be reviewed by the facility QA&A Committee meeting monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Director of Nursing and unit managers will be responsible for overall compliance.	8/9/2012
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow a physician's order for one (#1) of six residents reviewed. The findings included: Resident #1 was admitted to the facility on June 6, 2012, for short term rehabilitation after surgery for a torn Rotator Cuff. Medical record review of the physician's order dated June 12, 2012, revealed "...Debrox ear gtts (drops) 5 gtts in each ear qd (every day) X (times) 3 days then rinse..." Medical record review of the June 2012, Medication Administration Record (MAR) revealed the ear drops were scheduled to be administered on June 13, 14, and 15, and then the ears were to be rinsed. Continued review			

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F 281	Continued From page 2 revealed no initials indicating the nurse administered the ear drops on June 13, 14, or 15, 2012. Interview on June 26, 2012, at 3:15 p.m., in the hallway near the third floor nurse's desk, with the third floor Unit Manager revealed the nurse who worked on June 13, 2012, could not remember administering the ear drops, the nurse who worked on June 14 and 15, 2012, administered the ear drops on the June 15, 2012, but forgot to sign the MAR. Further interview with the third floor Unit Manager confirmed the ear drops were not administered as the physician ordered.	F 281	Corrective Action and Identify areas having the potential to be affected: Resident #1's physician was notified and order received for debrox and placed on the medication administration record on 6/27/2012. Identifying Other Residents Unit managers reviewed medication administration records for documentation of medications being administrated to residents.	8/9/2012
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.		Systemic Changes: The facility unit managers will complete a weekly audit for 4 weeks then twice a month for 8 weeks of the medication administration records for completion and appropriate documention. The DON educated the facility administrative nurses on reviewing the medication administration records. The staff development coordinator completed education with the licensed nursing staff on; administration of medications and documentation on the medication administration records.	

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F 441	Continued From page 3 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide interventions to prevent contamination for one (#6) of six residents reviewed. The findings included: Resident #6 was admitted to the facility on January 25, 2012, and re-admitted on May 27, 2012, with diagnoses including Multiple Cerebral Vascular Accidents (CVA), Respiratory Failure, Multiple Episodes of Pneumonia, Urosepsis, Tracheotomy, Colostomy, Dysphagia (difficulty swallowing) and Peg Tube Placement (feeding tube inserted into the stomach). Medical record review of the hospital's History and Physical dated June 13, 2012, revealed the resident was hospitalized with Pneumonia and Urosepsis (severe urinary tract infection).	F281 F441	Monitoring: Results of the audits will be reviewed by the facility QA&A Committee monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Administrator, Director of Nursing and unit managers will be responsible for overall compliance. Corrective Action and Identify areas having the potential to be affected: On 6/27/2012 Resident #6-the unit manager removed the formulas and suction items from the resident's care area and discarded. Identifying Other Residents On 6/27/2012 resident rooms were reviewed by nursing and housekeeping for items at the bedside that needed discarded.	8/9/2012 8/9/2012

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F 441	Continued From page 4 Observation on June 27, 2012, at 7:20 a.m., in the resident's room with Licensed Practical Nurse (LPN) #2 and LPN #3, revealed an open container of sterile Normal Saline used to suction the resident's tracheostomy on the bedside table, tubing approximately four foot long (with formula in it) on the floor, and formula spilled on the floor. Interview on June 27, 2012, at 7:20 a.m., in the resident's room with LPN #2 and #3, confirmed the formula in the tubing and on the floor provided a breeding ground for bacteria, and the open container of Normal Saline was open, contaminated, and available for licensed staff to use to suction the resident.	F 441	Systemic Changes: An audit will be completed by the unit managers and housekeeping to observe resident care areas for breaches in infection control techniques. This audit will be completed twice weekly for 2 weeks, then weekly for 2 weeks then monthly for three months. The staff development coordinator completed education with the nursing staff, housekeeping staff and respiratory staff regarding infection control techniques to prevent spread of infection to residents. Monitoring: Results of the audits will be reviewed by the facility QA&A Committee monthly for 3 months with revisions to the plan as deemed appropriate by the QA&A Committee. The Administrator, Director of Nursing and infection control nurse and unit managers will be responsible for overall compliance.	8/9/2012